Clover Health

Utilization Management Program Description

2023

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1. PURPOSE

The Clover Health Utilization Management (UM) program provides a systematic method to manage the utilization of services provided to enrollees by providers in the Clover network, while supporting its mission of helping its members live their healthiest lives. The UM program adheres to Clover's core values of honesty, integrity, and excellence in business operations and delivery of healthcare services. Clover will strive to serve the needs of its members, participating providers, employees, and the communities within its service area. Management of services is achieved through evaluation of appropriateness of services provided based on medical necessity and ongoing performance monitoring and improvement activities, as set forth in this UM Program Description. The program is implemented and administered by the Clover Clinical Operations team in accordance with the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS). This program description details the scope, goals, structure, authority, and operations of the Clover UM program.

2. SCOPE

The Clover UM program consists of a set of activities that promote the appropriate allocation of health resources for members enrolled in a Clover PPO or HMO plan. The UM program is designed to ensure members receive services:

a. In the amount, duration, and scope deemed medically necessary to prevent, diagnose, improve, or cure conditions which may cause acute suffering, endanger life, result in illness or infirmity, interfere with the member's capacity for normal activity, or threaten some significant handicap.

b. In a cost effective and efficient manner.

c. In the most appropriate setting for the intensity of services required.

d. In accordance with the applicable requirements outlined by the American Disabilities Act, The Center for Medicare and Medicaid Services Member Rights, and the individual state department of Health as applicable.

The UM Program Description is intended to serve as a guide for conducting UM activities. Clover covers all items and services required as specified by the federal programs. UM at Clover is conducted in a collaborative method which includes the Utilization Review team, the Wellness Nurse Care Manager team, the member's provider(s), and the member. Processes used within the context of UM include: benefit verification, prospective, concurrent, retrospective review, clinical policy development, discharge planning, and other Wellness Nurse Care Manager activities.

3. PROGRAM GOALS AND OBJECTIVES

The goal of the Clover UM program is to ensure our members are receiving medically necessary care through delivery of cost effective, high quality services in the most

appropriate setting required. In order to achieve this goal, The UM program shall execute the following objectives:

1. Collaborate with the Wellness Nurse Care Manager team, providers, members, and others involved in the delivery of healthcare services to promote a culture that is relevant [to] and respectful of the member's needs.
2. Ensure authorized services, procedures, and treatments are consistent with the member's plan structure and benefit allotment.
3. Employ nationally recognized UM standards. Adopt objective and evidenced-based guidelines, protocols, and criteria that support appropriate clinical decision-making;
4. Render UM decisions based on medical necessity criteria (MNC) in a timely and effective manner.
5. Facilitate that services are provided in the amount, duration, scope, and exigency deemed appropriate based on the member's individual needs.
6. Facilitate and promote service provision by Participating Providers, unless otherwise indicated or authorized.
7. Collaborate with internal and external partners to support coordination of services and continuity of care.
8. Monitor activities to:
    a. Identify inappropriate or duplicative services, procedures, or treatments.
    b. Identify and correct under-utilization of services, procedures, or treatments, which may benefit the member.
9. Report any known or suspected fraud and abuse.
10. Collaborate with and/or provide notification to the Wellness Nurse Care Managers if any [known] event or authorization request could potentially impact the member's risk level, service needs, or plan of care.
11. Adhere and comply with all rules, regulations, guidelines, and standards established by the Centers for Medicare and Medicaid Services.
12. Promote transparency and continuous quality improvement through the integration of the Annual UM Work Plan and UM Program Description.

4. ORGANIZATIONAL STRUCTURE

The UM program is administered by the UM team, which is a subsidiary of the Clover Clinical Operations team. Staff involved in UM activities or functions, whether directly or indirectly, carry out their responsibilities as defined by the scope of practice for their individual professional discipline(s) and assigned job description.

5. STAFFING AND ACCOUNTABILITY

It is the position of Clover that, regardless of role or position, all employees have an impact on the delivery of healthcare services; and therefore have a responsibility to: conduct themselves in a manner consistent with Clover's mission and corporate values; adhere to company policies; reduce tyranny in the healthcare system through monitoring and reporting of [known or suspected] quality of care issues, fraud and abuse; and to serve Clover members in an ethical, dignified, and respectful manner.

5.1 UM Staff

Senior Medical Director

The Senior Medical Director is a physician with an active medical license who is responsible for the purpose, goals, objectives, and strategic planning of the UM program, and serves as the chairperson for the Medical Management Committee (MMC). The Senior Medical Director reports to the CMO Responsibilities include:

- Final administrative review and approval of the Annual UM Program Evaluation and Annual UM Work Plan.
- Final administrative review and approval of all UM program standards, including clinical policies.
- Providing medical leadership, expertise, consultation, and education to UM staff.
- Serving as a liaison between Clover and provider partners when formal communication(s) or education is indicated.
- Issuance of final determinations related to payment of services based upon eligibility or medical necessity for services.
- Communication with providers as needed throughout the UM and Wellness Nurse Care Manager processes, to facilitate or support access to care and services for Clover members.
- Review, intervention, and reconciliation [negotiation] with provider partners in instances of questionable practices including, but not limited to; inappropriate allocation of services and medical necessity discrepancies.
- Preparation and/or Implementation of the UM Annual Work Plan the Annual UM Program Evaluation, as well as maintenance of the UM Program Description.

Director of UM

The Director of UM reports to the Chief Medical Officer (CMO), and is responsible for direction and oversight of the UM staff, day-to-day activities, and program objectives. Responsibilities include:

- Monitoring UM federal and state laws, regulatory requirements, and applicable accreditation standards, to ensure compliance.
- Planning, organizing, and directing staff of the UM team, including oversight [or

delegation] of team orientations and education.

- Development, implementation, and oversight of UM standards, criteria, policies and procedures; and monitoring [staff] adherence.
- Periodic review of UM team policies and procedures, as well as [other] departmental policies and procedures which may be relevant or impactful to program functions or objectives.
- Collaboration with [other] teams such as Member Services, Provider Services, Grievance and Appeals, and Compliance to identify opportunities for: improved member or provider satisfaction, quality, compliance, or general business operations.
- Analysis of data related to UM activities, services, members, and provider partners, for the purpose(s) of: predicated federal and state reporting requirements, identification of over or under utilization of services, and quality improvement or cost savings opportunities.
- Develop and Implement Corrective Action Plans (CAPs) when indicated.
- Support UM staff in the application of appropriate medical policy or clinical decision-making criteria throughout the utilization review process.

Behavioral Health Practitioner

The Behavioral Health Practitioner is responsible for directing and implementing behavioral health aspects into the UM program. Responsibilities of the Behavioral Health Practitioner include:

- Performing behavioral health UM reviews based on medical necessity and application of appropriate medical policy or clinical decision-making criteria.
- Adherence to timeliness standards for completion [and notification] of UM organization determinations, with consideration for medical exigency, as specified in UM program policies and federal regulatory guidelines.
- Performing routine behavioral health clinical Quality Assurance (QA) case audits as needed.
- In concert with the Senior Medical Director, quality reviews will be done to facilitate the effectiveness of the behavioral health aspects of the UM program in order to improve the quality of care and service provided to members
- The Behavioral Health Practitioner will be responsible for care management collaboration and referral for members as needed.
- The Behavioral Health Practitioner will also build relationships with psychiatric facilities.

Clinical Staff

UM staff who function in a “clinical” role are qualified, licensed, health professionals.

Clinical Functions and Responsibilities include:

- Performing UM reviews based on medical necessity, and application of appropriate medical policy or clinical decision-making criteria.

- Adherence to timeliness standards for completion [and notification] of UM organization determinations, with consideration for medical exigency, as specified in UM program policies and federal regulatory guidelines.
- Performing routine clinical Quality Assurance (QA) case audits to support delegation oversight and monitoring of UM vendors.
- Only licensed physicians or pharmacists can make adverse determinations on authorization requests as appropriate.

Non-Clinical Support Staff

The term UM Service Coordinator or Specialist is used to describe administrative staff who support UM activities. UM Service Coordinators are limited to collection and transfer of non-clinical or structured delegated clinical activities that do not require clinical evaluation, interpretation, or intervention.

Administrative functions and responsibilities include:

- Intake screening and data collection related to authorization requests.
- Support development and/or maintenance of UM policies and procedures and associated Standard Operating Procedures (SOPs).
- Perform administrative delegation oversight and monitoring reviews to identify trends and errors in timeliness and regulatory processes.
- Address or escalate issues identified by other teams that are related to UM and/or the clinical care of members to ensure accurate and timely case processing, member satisfaction, and quality care delivery.
- Work cross-functionally with Clover's Experience, Network, Claims, and Enrollment teams for resolutions of payment, coding, and eligibility issues.
- Correspond with internal staff, provider partners, and delegated vendors to answer questions regarding UM processes.
- Develop, maintain, and monitor UM team analytics to identify utilization trends, compliance measures, and opportunities for process improvement.

5.2 Medical Management Committee (MMC)

The Medical Management Committee is responsible for oversight, implementation, and maintenance of the UM program. In collaboration with the Quality Assurance Committee, the MMC monitors quality, continuity, coordination, and utilization of services; to promote compliance, ongoing process improvement, and effective delivery of healthcare services. The MMC is entrusted to review any discrete or aggregate UM issues or concerns, identify areas for improvement, and implement solution(s) or corrective action(s) as applicable.

The Medical Management Committee will be comprised of, but not limited to, the following

participants: the Chief Medical Officer, Senior Medical Director, the Manager of Quality Improvement (QI), Chief Operations Officer, the Director of Appeals, the VP of Ops Excellence, the VP of Pharmacy Operations, the VP of Insurance Operations, the Behavioral Health (B) Medical Director, two Participating Network Providers and the Compliance Officer. The MMC meets on a quarterly basis and as needed to fulfill the committee responsibilities.

In order to fulfill the aforementioned responsibilities, the Medical Management Committee members (or their delegates) shall execute the following actions:

1. Adopt, implement, and maintain UM program standards, criteria, policies, and procedures; and any associated documentation.
2. When indicated, monitor medical necessity determinations, relevant clinical information, and same [or similar] physician consultation(s).
3. Monitor overall effectiveness and process/quality improvement activities, including but not limited to, the Annual UM Program Evaluation and the Annual UM Work Plan.
4. Maintain knowledge related to trending UM performance measures.
5. Conduct inter-rater reliability (IRR) analysis to ensure consistency and accuracy in the application of UM standards and criteria.
6. Identify, evaluate, and resolve UM program issues, including over and under-utilization of services.
7. Develop provider education and communication programs that encourage effective and efficient delivery of services to members.
8. Document MMC meeting minutes, including any actions or decisions rendered by the committee.
9. Create ad hoc subcommittees to support or assist with MMC functions or initiatives.

5.3 Policy Subcommittee

The Policy Subcommittee will be composed of members of the medical management committee depending on the specific policy that is up for review during any given meeting. Some of the responsibilities of the Policy Subcommittee include:

1. Meet on an as-needed basis whenever there is a policy that needs to have changes/ updates reviewed and approved.
2. Review non-clinical (administrative) policies for preliminary approval before sending to the Quality Improvement Committee (QIC) for final approval.

5.4 Quality Improvement Committee (QIC)

The MMC is a subordinate committee of the Quality Improvement Committee (QIC). For details about the QIC refer to the QIC Charter. The QIC will do the following:

1. Final review of all UM policies after they have been reviewed and approved by the Policy Subcommittee. In order to approve a policy, it must be approved by the majority of the voting members.
2. If policies are needing review more quickly, the QIC can provide feedback/approval via email.
3. Review, analyze, recommend, and approve of all Quality Improvement activities.
4. Monitor and support the implementation of the Quality Improvement program and Work Plan.

5.5 Delegation Oversight and Vendor Management

The Clover UM team is responsible for the oversight of all UM activities for covered services, even if there is a delegation of these functions. For any delegated function, including vendor management, Clover and the delegated entity will have a mutually agreed upon document that is signed and dated. This document will describe the following: the responsibilities of Clover and the delegated entity, the delegated activities, the frequency of reporting to Clover, the delegated entity's performance evaluation process by Clover, as well as remediation options which may include the revocation of the delegation, if the delegated entity does not fulfill its obligations.

6. UM PROGRAM FUNCTIONS

The primary function of the UM program is to complete medical necessity reviews for services requested, based on the member's individual healthcare needs; with consideration for: benefit allowance per medical policy and the member's evidence of coverage (plan contract), clinical criteria for appropriate allocation of services or level of care, medical exigency, and cost effective delivery.

6.1 Clinical Decision-Making Criteria

Clinical coverage decisions are based on the eligibility of the member, state and federal mandates, the members certificate of coverage, evidence of coverage or summary plan description, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and other evidence based clinical literature.

The Clinical Review team utilizes evidence based MCG criteria to guide hospital admission and level of care reviews. Application of clinical review criteria is integral to the UM process of clinical coverage review and inpatient admission review. Clinical review criteria are internally accessible via a fully licensed internet based site that is available to all clinical staff. Clover may also develop clinical review criteria with review and input from appropriate providers and based on current clinical principles and processes and evidence based practices.

The Clover Medical Management Committee reviews, evaluates and approves the clinical review criteria annually or more frequently as appropriate. The Medical Management Committee submits approved clinical review criteria to Clover Quality Improvement Committee for final review and approval.

The Clover Medical Management Committee is responsible for developing and approving all new and revised medical policies. Medical policies are developed to assist the UM team in accurately reviewing service requests within the context of the contract language in a plan document. New policies are developed in response to emerging technology or new treatments and are based on scientific evidence, where such evidence exists. Medical policy updates are communicated to all UM staff through Clover internal electronic communication.

6.2 Medical Necessity Reviews

Requests for utilization reviews may be submitted electronically, telephonically, via facsimile, or in writing to the UM team. Authorization requests may be submitted by a provider, on behalf of the member; or by the member [or authorized member representative] as a self-referral. All utilization review requests, related clinical information, and any review activities associated with the request are documented in the system of record. Members and providers are notified [verbally and/or in writing] in conformance with applicable timeliness standards, regulatory, and statutory requirements; of the determination. The types of utilization review(s) included in the scope of the UM program are:

Prospective Review – Often termed prior authorization or pre-authorization, this review is conducted prior to a member's service administration or course of treatment being initiated. The term precertification may also be used when describing a prospective review for an acute, intermediate, or long term admission to a hospital or care facility.

At Clover, UM staff conduct prior authorization reviews of all requested services that require pre-authorization. All prior authorization requests must be submitted in compliance with Clover's UM policy, following the procedure(s) detailed in the Member Handbook, Provider Manual, or verbal instruction from qualified staff. Information and education is provided to members and providers to inform them on prior authorization requirements and criteria; how to request and obtain prior authorization for services; and what rights are afforded to members and providers if a request for a service or course of treatment is denied.

Concurrent Review – Conducted during a member's admission, course of treatment, or when services are actively being provided. The terms Continued Stay Review or Extension of Services may also be used for Concurrent review of inpatient admissions or request for additional services, respectively.

At Clover, UM staff conduct concurrent review(s) on requests for extension of previously approved treatments or services administered in an inpatient or outpatient setting, including, but not limited to: Acute Inpatient Hospitalization, Home-Based Care Services, Rehabilitation Therapies, Community Based Programs, and Durable Medical Equipment (DME) or Supplies.

Retrospective Review – Request for an organization determination from the UM team after care or services have been provided may result in a dismissal for untimely notification. Prior authorization review can not be completed for a service that has already been provided to a member. Providers who receive a dismissal of a retrospective authorization request may submit a claim to Clover for the services provided. If an initial organization determination has not been issued by the UM team through prior authorization and a claim is received for care or services that require authorization, then the initial organization determination will be made through claims processing.

Providers contracted with Clover that provide a service without submitting a prior authorization will not have appeal rights and should refer to their contract regarding payment denial. All non-contracted providers are allowed applicable appeal rights for adverse determination in accordance with CMS guidance.

7. UM PROGRAM REQUIREMENTS

7.1 Member Access to Services

UM staff are accessible to members and providers by toll-free telephone:

a. Directly – no less than forty (40) hours per week during normal business hours for purpose(s) of receiving calls related to member care including: request for services, notification of admission or transition, and quality of care concerns. Normal business hours are defined as 8 am to 8 pm ET, Monday through Friday, excluding federally recognized [public] holidays.

b. Indirectly – Calls received outside of normal business hours, including evenings and weekends, will be routed to a voice messaging system. Calls are returned within 1 business day.

Inbound phone calls are answered by appropriate staff with an introductory greeting which identifies the name of the call recipient, the name of the organization (Clover Health), and the name of the team (UM, Member Services, etc.). Based on the source and/or purpose of the incoming contact; the caller is transferred to the relevant or requested team, or individual staff person, via “warm transfer” whenever possible (and appropriate). Clinical staff receiving calls will identify themselves by name, title, and team. All staff who are requested [to] or involved in the exchange of any member information will verify the caller’s purpose and relationship to member and, when applicable, validate consent for divulgence of information, prior to disclosing any personal health information. Staff are required to return calls within 1 business day or as expeditiously as the situation requires, based on medical exigency. If a staff person is unavailable for any extended period of time, it will be indicated on his or her personal voicemail, along with the contact information for an alternative staff person or resource.

7.2 Separation of Medical and Fiscal Decisions

No person(s) involved in the UM review process may receive compensation or incentives, financial or non-financial, directly or indirectly, to deny or delay approval for [covered] services deemed medically necessary. Clover does not reward internal or external providers for limiting or withholding services, promoting under-utilization, or issuing adverse determinations.

7.3 Appropriate Professionalism and Confidentiality

Clover adheres to the Centers for Medicare and Medicaid services (CMS) requirements related to the use of appropriate professionals in conducting reviews for medical necessity. Pursuant to statutory and regulatory guidelines, utilization review activities are conducted in a collaborative method by:

- Administrative personnel trained in the principles and procedures of intake screening and data collection; under the supervision of a licensed healthcare professional.
- Licensed [clinical] healthcare professionals who are appropriately trained in the principles, procedures, and standards of the UM program.
- A Medical Director or physician designee (peer reviewer) when the review involves a partial or fully adverse determination.
- At Clover, enrollee and practitioner information is confidential; therefore all internal staff, external [contractual or consulting] staff, external provider partners, and any other persons who act for, or on behalf of Clover are required to comply with designated confidentiality policies and procedures.

7.4 UM Timeframes for Organization Determinations

It is the right of all Clover members to receive medically necessary services in a timely manner. In order to facilitate the delivery of quality, efficient care to members; the Clover UM program adheres to the general timeliness standards listed below for review, additional information requests, extensions, and notification of authorization request determinations, unless otherwise specified or indicated.

Any request received is considered **“Standard”** or non-urgent, unless it is deemed urgent by the clinical reviewer or the requesting provider, in which case, the review is **“Expedited.”** Per federal law and definition: An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee’s life, health, or ability to regain maximum function in serious jeopardy.

At Clover, each request received is assessed for medical exigency, and **all UM reviews are conducted as expeditiously as the member’s health condition requires.**

Prior Authorization and Concurrent Review

- Standard request for coverage of items or services – Determination shall be made within

14 days from the receipt of the request.

- Standard request for coverage of Part B drugs – Determination shall be made within 72 hours form the receipt of the request.
- Expedited request for coverage of items or services – Determination shall be made within 72 hours of the receipt of the request.
- Expedited request for coverage of Part B drugs – Determination shall be made within 24 hours from the receipt of the request.
- Extension – Clover may invoke an extension for up to 14 days following the receipt of a standard or expedited pre-service organization determination if:
  - The enrollee requests the extension or
  - if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee and
  - The authorization request is not for coverage of a Part B drug (extensions are not allowed per CMS guidance for Part B drug authorizations)

Additional details related to [making] organization determinations including timeliness, regulatory references and verbal/written notification specifications, can be found in the related policies and procedures.

8. UM PROGRAM ACTIVITIES

8.1 Analysis of Utilization Patterns

Under the guidance of the Chief Medical Officer (CMO), Senior Medical Director, and the Director of UM; the UM team monitors, reviews, tracks , and analyzes, utilization data to identify atypical patterns, including: over and under-utilization, inappropriate utilization, hospital readmissions, length of stay by diagnosis or episode, emergency room visits, and out-of-area/out-of-network services and hospitalizations. Internally, the UM team monitors patterns in: service denials, UM grievance and appeals, and inter-rater reliability (IRR) performance; to ensure consistent and compliant application of UM program standards, criteria, policies and procedures. The information gathered is used to identify potential [or known] opportunities for improvement, as they relate to UM program activities; as well as to support the development of Corrective Action Plans (CAPs) which, when indicated, are implemented and monitored by the UM team.

8.2 Annual UM Work Plan and UM Program Evaluation

The Annual UM Work Plan is drafted through the collaborative efforts of the Chief Medical Officer, Senior Medical Director and the Director of UM; and sets forth the goals and objectives of the UM program including:

- Processes for monitoring and improving the UM program.
- Annual improvement initiatives that support the goals of the UM program.
- An implementation timeline for each initiative, along with details specific to the work

group(s) or individual(s) responsible for deliverables.

The Annual UM Program Evaluation will be prepared by the Senior Medical Director and presented to the Medical Management Committee for review and approval. It will report on the UM program activities and outcomes from the previous year, including, but not limited to:

- An evaluation of UM program effectiveness and efficiency.
- The impact of process improvement initiatives.
- Areas for improvement in the UM program.
- Short and long term initiatives that will be evaluated for inclusion in [future] UM program activities.

Each of the Annual UM Work Plan and UM Program Evaluation will be presented to the QIP Committee for review and approval as well as with the Medical Management Committee to assist in collaborative efforts towards improved quality measures, member/provider satisfaction, and overall program effectiveness.

The participating Medical Management Committee members, consisting of the CMO, Senior Medical Director, Director of UM, Behavioral Health Practitioner and any other delegates, will annually reassess, amend, and approve the UM Program Description and UM Work Plan. Criteria used in decision-making will be reviewed on an annual basis. UM and [other] related departmental policies and procedures will be reviewed annually by the MMC.

9. UM PROGRAM INTEGRATION AND INTERDEPARTMENTAL COORDINATION

9.1 Wellness Nurse Care Manager Team

At Clover, Wellness Nurse Care Managers are crucial to ensuring members receive the appropriate type and level of care [services] in a timely and relevant manner. The UM team works closely with the Wellness Nurse Care Manager team to promote member autonomy through the provision of treatments and services that allow the member to live safely in his or her home for as long as possible. Collaboration and transparency between the UM and CM programs supports Clover's member-centric, holistic, and culturally sensitive approach to health management; while also serving to improve overall outcomes and reduce healthcare spending through minimizing the rate of unnecessary hospitalizations, readmissions, emergency room visits, and [further] physical or functional deterioration.

10. Appeals and Grievances

For information on appeals and grievances, refer to Organization Determinations (Prior Authorizations), Grievances, and Appeals at **cloverhealth.com/members/plan-documents/appeals-grievances**.